March 9, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-04-0835-01-SS

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 65 year-old male who sustained a work related injury on ___. The patient reported that while driving an 18-wheeler, he attempted to slow down while turning to the right when the truck rolled over. A neurological evaluation note dated 1/20/04 indicated that the patient had sustained multiple fractured bones, cervical spine injury as well as head injury and was hospitalized for a long period of time. It indicated that the patient suffered from chronic lumbar radiculopathy that was reported to have begun after the initial accident. It further indicated that the patient had undergone a laminectomy at the L4-L5 and L5-S1 levels. It further indicated that an MRI from 6/03 showed complete collapse of intervertebral disc at the level of L4-L5, foraminal stenosis bilaterally resulting in significant nerve root compromise and nerve root impingement, particularly bilaterally. An office progress note from an orthopedic surgeon dated 1/7/04 indicated that the patient was being evaluated for a second opinion concerning lumbar spine fusion. It also indicated that the patient was status post right rotator cuff surgery. It further indicated that the examination of the patient's lumbar spine revealed tenderness in the paravertebral muscles, flexion 40 degrees, knee jerks equal and normal bilaterally, absent ankle on the jerks left, decrease ankle jerks on the right and positive straight leg raise bilaterally to 70 degrees. The recommendation from this progress note was psychological evaluation and lumbar spine surgery at the L4-L5 and L5-S1 levels.

Requested Services

Left Facetectomies at L4-L5, bilateral foraminotomies at L4-L5 and L5-S1, discectomies and TLIF at L4-L5 and L5-S1, PSF at L4-S1, instrumentation, ICBG, and fluoroscopy.

Decision
The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a 65 year-old male who sustained a work related injury to his cervical and lumbar spine, and head on ___. The ___ physician reviewer explained that the patient is status post a failed lumbar spine surgery. The ___ physician reviewer also explained that the patient has no documented evidence of spinal instability. The ___ physician reviewer further explained that the documentation provided does not support the medical necessity of the requested surgery. Therefore, the ___ physician consultant concluded that the requested left facetectomies at L4-L5, bilateral foraminotomies at L4-L5 and L5-S1, discectomies and TLIF at L4-L5 and L5-S1, PSF at L4-S1, instrumentation, ICBG, and fluoroscopy are not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2))

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 9th day of March 2004.